

**WISCONSIN MEDICAID  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR GROWTH HORMONE DRUGS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions, HCF 11092A. If a growth hormone drug is prescribed for a Wisconsin Medicaid recipient, prescribers are required to complete this form and submit it to the pharmacy where the prescription will be filled.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List for Growth Hormone Drugs form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a paper PA request.

**SECTION I — RECIPIENT INFORMATION**

1. Name — Recipient (Last, First, Middle Initial)

2. Date of Birth — Recipient

3. Recipient Medicaid Identification Number

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name

5. Strength

6. Date Prescription Written

7. Directions for Use

8. Diagnosis — Primary Code and / or Description

9. Name — Prescriber

10. Drug Enforcement Agency Number

11. Address — Prescriber (Street, City, State, Zip Code)

12. Telephone Number — Prescriber

13. **SIGNATURE** — Prescriber

14. Date Signed

**SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS**

15. Has the recipient tried and failed a preferred growth hormone drug? Preferred growth hormone drugs include Norditropin, Nutropin AQ, Saizen, and Tev-Tropin.

☐ Yes

☐ No

16. Is the recipient's chronological age under 20 years?

☐ Yes

☐ No

17. If the recipient's chronological age is 20 years or older, is the skeletal age of the recipient documented to be 18 years of age or younger?

☐ Yes

☐ No

18. Is the prescription for the growth hormone drug written by an endocrinologist?

☐ Yes

☐ No

19. Does the recipient have a diagnosis of growth deficiency?

☐ Yes

☐ No

20. Does the recipient have a diagnosis of Prader Willi or Turner's Syndrome?

☐ Yes

☐ No

21. Does the recipient have a recent stimulated response growth hormone test demonstrating a clear abnormality?

☐ Yes

☐ No

Indicate the test result. \_\_\_\_\_

Indicate the normal range. \_\_\_\_\_

*Continued*

**SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA**

**22. Diagnosis** **Response (Indicate "1" for yes or "2" for no.)**

- A) The recipient is 18 years of age or older. \_\_\_\_\_
- B) The recipient has Human Immunodeficiency Virus (HIV) with serum antibodies to HIV. \_\_\_\_\_
- C) The recipient is female and pregnant or lactating. \_\_\_\_\_

**23. Recipient's Current Medical Condition**

- D) The recipient has signs or symptoms of Acquired Immune Deficiency Syndrome (AIDS) or associated illnesses. \_\_\_\_\_
- E) The recipient has untreated or suspected serious systemic infection. \_\_\_\_\_
- F) The recipient has an active malignancy other than Kaposi's sarcoma. \_\_\_\_\_
- G) The recipient is on approved anti-retroviral therapy. \_\_\_\_\_
- H) The recipient has documented hypogonadism and is taking gonadal steroids. \_\_\_\_\_

**24. Evidence of Wasting Syndrome**

- I) The recipient has unintentional weight loss of at least 10 percent from baseline. \_\_\_\_\_
- J) The recipient has a gastrointestinal (GI) obstruction or malabsorption to account for weight loss. \_\_\_\_\_

Indicate the recipient's height (in inches). \_\_\_\_\_

Indicate the recipient's usual weight (in pounds) prior to diagnosis of HIV. \_\_\_\_\_

Indicate the recipient's current weight (in pounds). \_\_\_\_\_

**25. All of the following must be tried before beginning a course of therapy with a growth hormone drug.**

- K) The recipient is receiving at least 100 percent of estimated caloric requirement on current regimen. \_\_\_\_\_
- L) The recipient has tried and failed a previous trial with megestrol acetate and / or dronabinol. \_\_\_\_\_
- M) The recipient has completed a course of therapy of at least 24 weeks of protease inhibitors alone or with nucleosides. \_\_\_\_\_
- N) The recipient has completed a course of therapy using dihydrotestosterone (when appropriate). \_\_\_\_\_

**NEED LEVEL**

Enter all 14 digits for this section in the following spaces. Do not include the measurements for the recipient's height, usual weight, or current weight.

\_\_\_\_\_  
A B C D E F G H I J K L M N

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

26. National Drug Code (11 digits)	27. Days' Supply Requested*
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28. Wisconsin Medicaid Provider Number (Eight digits)

29. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

30. Place of Service (Patient Location) (Use patient location code "00" [Not Specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient].)

31. Assigned Prior Authorization Number (Seven digits)

32. Grant Date	33. Expiration Date	34. Number of Days Approved
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35. ☐ Check this box to indicate if additional information is necessary. Submit additional information on a separate sheet.